Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
ELLEN O TURNER DO

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-14-2301-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
MARCH 17, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We are in dispute of payment because these were denied for timely but we originally sent to the company Botanical and they acknowledged receipt of claims but they were not ever sent to Texas Mutual until we sent them again around 12/2013. We have since had to make several follow up calls and provided proof on these claims"

Amount in Dispute: $4,950.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual on 12/11/13 received a bill from **PARK CITIES DERMATOLOGY PA**. Rule 133.20(b) states, 'Except as provided in Labor Code §408.0272(b), (c) or (d), a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided. In accordance with subsection (c) if the statute, the health care provider shall submit the medical bill to the correct workers' compensation insurance carrier not later than the 95th day after the date the health care provider is notified of the health care provider's erroneous submission of the medical bill. A health care who submits a medical bill to the correct workers' compensation insurance carrier shall include a copy of the original medical bill submitted, a copy of the explanation of benefits (E)B) if available, and sufficient documentation to support why one or more of the exceptions for untimely submission of a medical bill under §408.0272 should be applied.' The rationale given by the requestor does not meet the exception criteria the Rule above."

Response Submitted by: TEXAS MUTUAL INSURANCE CO

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 4, 2013	Professional Services	$4,950.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.20 sets out the procedures for medical bill submission by the health care provider.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 29 – The time limit for filing has expired.
   - 350 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
   - 724 – No additional payment after a reconsideration of services.
   - 731 – Per 133.20 provider shall not submit a medical bill later than the 95th day after the date the service for services on or after 9/1/05.
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Issues

1. Did the requestor initially bill the employer?
2. Is the requestor entitled to reimbursement?

Findings

1. According to the requestor's position summary that initially billed the claimant's employer. In accordance with 28 Texas Administrative Code §133.20(j)(1)(C) which states, in pertinent part, "A health care provider who elects to submit medical bills to an employer waives, for the duration of the election period, the rights to medical dispute resolution as provided by Texas Labor Code §413.031.
2. The requestor has waived the right to Medical Fee Dispute Resolution; therefore, the disputed date of service cannot be reviewed.

Conclusion

For the reasons stated above, the Division finds that the requestor initially billed the employer. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	November 13, 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.